# Meeting Report

# Health Information Technology Policy Committee

**May 11, 2009**

## Call to Order and Introduction of Committee Members

Dr. Blumenthal welcomed the group to the first meeting of the Health Information Technology Policy Committee and introduced Judy Sparrow of the Office of the National Coordinator for Health Information Technology (ONC). Ms. Sparrow reminded the group that they are operating under the Federal Advisory Committee Act (FACA), meaning that the meeting was being conducted in public. Each FACA meeting provides the opportunity for public comment, and a transcript of the proceedings will be made available on the ONC Web site. Ms. Sparrow acknowledged the large number of stakeholder groups represented at the meeting and asked that any individuals who have a conflict of interest to make full disclosure during roll call. Then Ms. Sparrow conducted the roll call of those present at the table and on the telephone, as follows:

| | |
|---|---|
| **David Blumenthal, M.D., Chair** | HHS/ONC |
| David Bates, M.D. | Brigham and Women's Hospital |
| Christine Bechtel | National Partnership for Women & Families |
| Neil Calman, M.D. | The Institute for Family Health |
| Richard Chapman | Kindred Healthcare |
| Adam Clark, Ph.D. | Lance Armstrong Foundation |
| Arthur Davidson, M.D. | Denver Public Health Department |
| Connie White Delaney, Ph.D, R.N. | University of Minnesota/School of Nursing |
| Paul Egerman | Businessman/Entrepreneur |
| Judith Faulkner | Epic Systems Corporation |
| Gayle Harrell | Former Florida State Legislator |
| Charles Kennedy, M.D. | WellPoint, Inc. |
| Michael Klag, M.D. | Johns Hopkins University, Bloomberg School of Public Health |
| David Lansky, Ph.D. | Pacific Business Group on Health |
| Deven McGraw | Center for Democracy & Technology |
| Frank Nemec, M.D. | Gastroenterology Associates, Inc. |
| Marc Probst | Intermountain Healthcare |
| Latanya Sweeney, Ph.D. | Carnegie Mellon University |
| Paul Tang, M.D. | Palo Alto Medical Foundation |
| Scott White | 1199 SEIU Training and Employment Fund |

## Opening Remarks

Dr. Blumenthal welcomed and thanked everyone present, acknowledging that the group has a lot of work to do in a very short period of time. He noted that later in the week, the first session of the Health Information Technology Standards Committee will convene. Dr. Blumenthal said he felt this group needed to meet ahead of the Standards Committee, in that at least in statute, the Policy Committee is charged with instructing the Standards Committee with regard to where that group should focus its attention moving forward, particularly in terms of which standards to focus on. Additional goals of this first Policy Committee meeting were to have Committee members familiarize themselves with each other

and begin to set priorities for their work. This work will be guided in many ways by the charges that Congress has outlined, and deadlines that Congress has set.

Dr. Blumenthal, newly appointed as National Coordinator for Health Information Technology, explained that he brings a deep and abiding interest in health care reform to the position. He encouraged the group to think of themselves not as people focusing on health information technology, but rather focusing on how to make our health system better. He noted that there are two critical components to the President's overall agenda, and increasingly that of Congress, as well. One focuses on coverage; the other focuses on improving health system performance. These two components are interrelated—the coverage goal cannot be met unless system performance goals are achieved. Dr. Blumenthal added that the President was hosting a meeting at the White House on the same day as this Policy Committee meeting to discuss how to make the nation's system more efficient to uncover resources that can be used to extend coverage. It is expected that the topics being discussed by Committee members at this meeting will be frequently mentioned by those attending the meeting at the White House.

Dr. Blumenthal noted that the health information technology provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) address improving population health, individual health, and health system efficiency. That is why the Policy Committee will be focusing on the meaningful use of health information technology, rather than explicitly on the adoption of health information technology. Dr. Blumenthal also explained that the Health Information Technology Policy and Standards Committees are held in public, have the goal of providing the public with access to important deliberations that are in the public's interest. These committees function according to very specific statutory rules regarding transparency and process. These rules are in keeping with the spirit of the legislation and with the administration's interest in openness and transparency.

## Response to Dr. Blumenthal's Remarks

Mr. Chapman asked if there was a third group dealing with the issue of meaningful use. Dr. Blumenthal indicated that there is no formal third group; there are only two FACA committees, and the definition of "meaningful use" will be developed with this group's assistance. Jodi Daniel, ONC, clarified that Ms. Daniel clarified that the National Committee on Vital and Health Statistics (NCVHS) is another committee that has interest in this area. The HIT Policy Committee will need to work closely with NCVHS to clarify the issues to be considered and where they might also have a role to provide advice to the Department of Health and Human Services (HHS) on related activities. She acknowledged that there is some intersection—the statute calls for the HIT Policy Committee to consider any recommendations from NCVHS, which will bring those recommendations to the HIT Policy Committee for discussion.

Mr. Probst asked whether there is an inherent sequence to standards (i.e., if one of the outcomes is to provide guidance, is there some basic sequence that the standards should be in, so that they are in the proper sequence?). Dr. Blumenthal replied that the HIT Policy Committee is supposed to advise the HIT Standards Committee on this matter. In some sense, the standards follow the policies that recommended by the HIT Policy Committee. Dr. Lansky noted that the ONC released a strategic plan approximately 1 year ago and asked about how that plan plays into the architecture that may promote fitting into the guidance related to sequencing. Dr. Blumenthal commented that ONC recognizes the importance of strategic planning, and that in a perfectly rational world, this plan would be rolled out in an orderly fashion. The difficulty is that Congress set a series of deadlines, one of which was the meeting of the HIT Standards Committee later this week. Secondly, statute requires that an extension center program be posted in the *Federal Register* on May 18, 2009. This is a critical component of any strategic plan for working forward to achieve meaningful use. Third, the meaningful use requirement is attached to a 2011

timeframe. That timeframe gives very little pause for the purpose of designing policy to support the implementation of the 2011 meaningful use criteria. Therefore, Dr. Blumenthal explained, that the strategic plan will have to be developed in a parallel process along with getting these initiatives started. He encouraged Committee members to provide any suggestions and advice on these activities and processes.

## Review and Discussion of Committee's Scope: Statutory Language/ARRA

Ms. Daniel reminded Committee members that ARRA created the two FACA committees (the HIT Policy and HIT Standards Committees). She also noted that the HIT Standards Committee will advise on standards, implementation, and certification for electronic health records (EHRs).

The recommendations from the HIT Policy Committee will be forwarded to the National Coordinator for Health Information Technology. There will likely be a Vice Chair of this committee who will formally make these recommendations to the National Coordinator. Then, the National Coordinator and HHS leadership will consider the recommendations, which will have a strong bearing on ONC's efforts. Ms. Daniel noted that there is a separate process for accepting the committee's recommendations within HHS and considering them with respect to other priorities and activities. Once endorsed by the National Coordinator, however, the HIT Policy Committee's recommendations will be submitted to the HIT Standards Committee for its consideration.

It is expected that the HIT Policy Committee will help to set some of the priorities for the HIT Standards Committee to work within. The role of the National Coordinator and the ONC is to support both committees and make sure that the work coming out of the Policy Committee has the appropriate scoping for the Standards Committee. ONC also will serve to provide input to the Policy Committee on other work that might be related to the discussions and considerations so that the work carried out within the Policy Committee is consistent with and connected to ONC activities.

Ms. Daniel explained that the statute called for two specific areas of focus for the Policy Committee: (1) the setting of priorities for standards, which will influence the HIT Standards Committee's work; and (2) to recommend a policy framework for the development and adoption of a nationwide infrastructure that permits information exchange. She noted that there were eight specific areas that ARRA set forth for the HIT Policy Committee to consider, as follows:

- Technology to protect the privacy and security of information (and consider segmentation of information).
- Infrastructure for electronic use and exchange of information.
- Utilization of health records.
- Accounting for disclosure to tie to the new provisions and statutes for accounting for disclosures, which would be considered for regulatory activities.
- Using certified health records to improve the quality of health care.
- Technologies to render information unreadable or unusable (this is tied to the new breach notification in the statute; recently, HHS released guidance in area).

- Collection of demographic data.

- Addressing vulnerable populations.

Additional areas suggested for consideration by the HIT Policy Committee include telemedicine, public health, individuals' access to their information, and technologies to improve home health care.

Dr. Blumenthal acknowledged that the HIT Policy Committee is a work in progress and shared his thoughts about prioritizing the Committee's work. There is an enormous mandate that extends from privacy and security all the way to how to carry out post-marketing surveillance, how to monitor public health threats, how to alert the public and providers about epidemic disease, and how to get doctors and hospitals to adopt qualified EHRs. Because it would be extremely difficult to carry out all of these activities at once, setting priorities is essential. Congress has set certain statutory requirements and has put allocated between $30 and $45 billion in payments that are available to physicians, hospitals, and certain other qualified providers who demonstrate starting in 2011 and going through 2018 that they are meaningful users of certified, qualified, EHRs. That amount of money focuses the attention, and creates very important benefits and risks. Dr. Blumenthal added that this is the first time in the history of this set of technologies, and in the history of the health care system, that Congress has set about to correct some of the market failures that have inhibited the adoption of technologies that have been widely viewed as essential to improving the functioning of the health care system. These are technologies that have been widely adopted by most other western countries.

At the same time, the fact that the money is available in such a short period of time creates a challenge if the appropriate preparations—through regulation, policy development, and through on-the-ground support—are not made for providers who in good faith want to take advantage of the technologies and thereby have access to the funds that are promised to them. Dr. Blumenthal explained that if this challenge is not met, there is the possibility that a large amount of money will be wasted and that policymakers will be deeply disappointed with the investment that they made and may not be willing to support this effort in the future. Many doctors and hospitals will be disappointed with the federal government for not fulfilling a major responsibility. Therefore, the meaningful use 2011 deadline has ONC's attention in a very important way—this does not suggest that the other issues that are important to creating a highly functioning health care system are unimportant or should not be dealt with. Rather, Dr. Blumenthal explained, it speaks to the need for the HIT Policy Committee, ONC, and others to carry out significant policy development focused on the meaningful use 2011 deadline first, so that the middle and long-term issues that ultimately may be more important can be addressed.

There are a series of particular tasks that must be accomplished to fulfill responsibilities under the law and make meaningful use a meaningful idea. First, the HIT Policy Committee must define "meaningful use," which in many ways is a revolutionary concept. The Committee needs to pick up where the NCVHS left off. There is a group within ONC that is working with representatives from other agencies on this topic and is awaiting the Committee's advice. A second important issue that must be addressed is certification. Providers can only be compensated if they are using certified records in a meaningful way. Dr. Blumenthal commented that the Policy Committee needs to consider how the certification process fits with the agenda that has been created by Congress. There is a third set of issues relating to infrastructure support. The HIT ARRA provisions allocate $2 billion to ONC to help the nation's health care providers, public health agencies, and other interested parties prepare for the adoption and meaningful use of HIT. There are a number of suggested uses for these funds, including an extension center project and associated training activities. There are funds specifically appropriated to support health information exchange as well as a number of other suggested uses for these funds (e.g., training workers to help with adoption, use, and exchange). There also are funds available to states both for exchange support and also

to cover groups of providers who may not be eligible for Medicare and Medicaid incentives under the law.

Dr. Blumenthal noted that in the area of privacy and security, statute requires appointing a Chief Privacy Officer. HHS has instructions to place in every regional office a privacy officer, whose responsibility will to be keep track of privacy-related issues. In addition, public health and disease surveillance has risen up on the list of priorities for this Committee and for the federal government as a whole in terms of the role of HIT. Although there is infrastructure support for information exchange, exchange in itself at the national and local level constitutes a separate and important issue to address in the short and long-term. Dr. Blumenthal commented that exchange has its own set of challenges, and draws together and encapsulates all of the other issues in this area.

Mr. Chapman commented that given the ambitious schedule and the 2011 timeframe, it would seem that one of the early activities the Committee should set its sights on is how best to take advantage of work that has already been done by other groups. Dr. Blumenthal noted that the NCVHS hearings represent important initial work for the meaningful use discussion. He asked for any thoughts related to work that has been done and is ongoing related to supporting the adoption and use of HIT. He noted that some of the HIT Policy Committee members have participated, and in many cases have led, efforts to secure adoption and use within health care systems. There is a literature base on that topic, although its applicability and remains to be determined. Much work has been done in the area of privacy and security, and the Committee should take advantage of those efforts. The same can be said for the area of health information exchange, looking at precedent and the history of regional health information organizations (some HIT Policy members play a role in information exchange at the local level).

Mr. Egerman noted that he senses some urgency around the issue of certification. Although 2011 may seem like it is a long way away, it is actually a short cycle for vendors that have to address design and installation issues. He noted that clarification regarding certification requirements is needed (e.g., if a product was certified under the old rule, does that mean it will be certified again?).

Ms. Harrell commented that there is much work to be done to ensure meaningful use is achieved according to the statutory definition, including the exchange of data. She suggested that this topic be pushed to the top of the list of items to be addressed by the HIT Policy Committee. In this regard, much work is needed at the state level—many of the states are not prepared for this.

Mr. Egerman suggested that the group might look towards the goal and work backwards, or work bottom-up. Using certification for EHRs as an example, a top-down approach might be to focus on the measurable outcomes. In HIT use, the Committee could consider the care delivered, or the health status achieved. Then, much of the work on how to get there can be left to the innovative approaches, and the Committee can be less worried about the granular specification. It would also drive attention to the goals, reforming the way HIT outcomes and care are delivered.

Ms. Bechtel agreed with this approach and seconded Mr. Egerman's comments, explaining that if the Committee begins to look at care coordination and better medication reconciliation that would point to the data elements that are needed to achieve the outcomes. The question is, when the HIT Standards Committee receives the HIT Policy Committee's recommendations, what happens next? Dr. Blumenthal indicated that the process is still being refined, but that the Standards Committee is charged with making recommendations to the HHS Secretary about which standards to accept. HHS must post a set of rules by the end of the calendar year. Dr. Blumenthal suggested that the HIT Policy Committee provide the HIT Standards Committee with a list of areas on which it should focus initially. It would be a duplication of effort to indentify to the HIT Standards Committee exactly what standards to develop; rather, the HIT Policy Committee should suggest areas in which standards are needed, and perhaps a general approach or

philosophy to standards. Working groups should be formed that will report back to the HIT Policy Committee—it is possible to add non-committee members to these working groups where necessary.

Dr. Calman said that to push the notion of successful adoption, vendors must be responsible beyond the production of a product, to the successful implementation of the product. The same holds true with the problems associated with successful implementation. Vendors can have good and effective products, but if those that they sell them to are not supported and led through the process, the end result could be many cases of unsuccessful adoption. Mr. Calman suggested that an extension is needed, meaning that certification could include something like post-implementation assessment of the sites where products were implemented to ensure that there is meaningful use.

Mr. Chapman noted that although there is a good amount of consensus that outcomes are eventually meaningful, along the way the Committee should consider timing, because certification will have to deal with both the functional certifications that are present in the systems as well as the implementation process where the functions are actually applied and put to use. Ms. McGraw commented that sometimes, too much weight is given to certification. She thinks of it more in terms of functionality. For example, does the system have the basic functionalities to do what is being asked of it? That should be tied to how meaningful use is defined. For one piece to be the exchange of data, then the systems have to be certified that they can exchange data. It needs to be achievable, and the criteria should not be set so high that they are impossible to satisfy. Ms. McGraw also commented that certification tends to be a "one-shot" approach and may not be the most effective way to measure implementation.

Ms. Harrell suggested that given the short timeframe, the Committee needs to examine incremental steps and set a "ladder" to go step-by-step. As the process moves forward, the levels at which the standards are set should be increased. She voiced concern about the ability of vendors to establish a comprehensive EHR that is ready to be interoperable as well as develop the connectivity by 2011. She also expressed concerns about the ability of physicians and/or hospitals to implement these products under such a tight timeframe. Dr. Lansky added that the Committee should consider functionality as well as quality reporting and measurement. There may be certifiable functions associated with each of those areas, which could mean that single products do not have to have everything built into them.

Dr. Tang offered examples of top-down and bottom-up thinking. He explained that going from the top down with respect to coordination of care would also automatically prescribe the exchange of information. From the bottom up it would help to give people incremental steps and "pave the road." He then likened this process to the creation of interstate roads, which created a public utility and proscribed the width of vehicles. Over time, guardrails and other specifications were added and had to fit within the constraints of the public utility. Carrying that analogy into this conversation, Dr. Tang suggested that it would not be desirable to have every provider worry about how wide the interstate is and where it goes.

Dr. Davidson noted that the Committee might consider prioritizing the eight specific areas that ARRA set forth for the HIT Policy Committee to consider, as presented earlier by Ms. Daniel. Some of these areas might be easier for the Committee to tackle initially with regard to meaningful use. Ms. McGraw commented that if the Committee is taking the top-down approach, with the "top" being the definition of meaningful use, then the definition could be staged over time. This drives a lot of the incremental decisions that must be made about standards needed to ensure that medication management programs are implemented. Ms. McGraw explained that the question would be: what needs to be in place to drive the outcomes that we have decided are the first set that we want to achieve? Then, it would be possible to take some of the requirements that Congress laid out in ARRA and slot them in.

Dr. Lansky suggested that fairly broad principles that would direct the Committee to the priority areas should be considered. He noted that those eight areas will all happen with or without the Committee, and

they will happen more or less simultaneously—Dr. Lansky noted that the Committee could look for opportunities to leverage various activities against/with one another. In the area of quality measurement, this comes through a variety of processes and creates a strong incentive in support of the other HIT adoption efforts. If the Committee settles on medication management IT standards, Dr. Lansky explained that it would be beneficial to have measures reinforcing those, as well as those that are tied to long-term health outcomes. He added that if these principles can be articulated, it would provide the Committee with a litmus test to judge the individual priorities and look for places to get synergy. Dr. Calman agreed, and asked: if this is part of a health reform agenda and we are looking to use technology as transformational, what are the big things that we believe? He suggested that privacy and security, quality improvement, patient centeredness, and access to care are answers to this question. Dr. Calman did voice concern that if one engages in a process of exchange without considering whether or not a principle is the patient's ownership and control of their information, then one moves into directions that would, in the future, not allow for revisiting that fundamental principle. He asked if there was the opportunity to examine these types of issues before the Committee becomes too involved in its work.

In response to a question about the extent to which the law provides a framework for privacy and security, and the extent to which this Committee is free to develop such a framework, Ms. Daniel explained that her interpretation of the law is that it focuses on the Health Insurance Portability and Accountability Act (HIPAA) framework and provides modifications to the current HIPAA requirements that existed before ARRA. There are clearly a lot of areas that either will be outside of the HIPAA framework, or where the Committee and ONC can have conversations about how to advance what has been adopted in the statute. Ms. Daniel indicated that the Committee could engage in beneficial discussions about how to better protect information through technologies, and about the approaches to taking up privacy for health information exchange

Mr. Egerman asked whether the statute allows an individual patient to opt out of using electronic records altogether. Ms. Daniel replied that it does not have a specific provision for this, and that patient choice may be a topic for HIT Policy Committee discussion. Currently, the HIPAA privacy rules provide a floor of protections; state laws may be more protective or provide additional types of requirements for privacy.

Dr. Calman raised the issue of patient access to information. He pointed to examples of inaccurate information being transferred, noting that this is a significant concern. He also suggested that access to unidentified patient information on the part of public health agencies could be a topic for discussion. In New York State, there is almost open access to aggregated information for the purposes of disease surveillance. Dr. Calman emphasized the importance of having access to information from hospitals and physicians' offices, and for the Committee to consider the principle of whether or not this information should be available for use by public health for disease surveillance (and also whether it is appropriate to try to capture information about the prevalence of various diseases). This issue is of particular concern as it relates and applies to vulnerable populations.

Dr. Blumenthal commented that regardless of what this group chooses as their priorities, many of the issues discussed today will go forward in parallel process. This Committee does not have to take up everything that is part of the statute, or is on the agenda. It may be more beneficial to select a few areas and focus on them. Dr. Blumenthal indicated that he is hearing from the discussion that there is an emphasis on privacy, security, and the role of the patient in HIT policy. He also heard a focus on how to define meaningful use in the most effective way, so as to inform other policy development. Finally, he heard a focus on certification and designing a process that was useful but not obstructive of innovation, and not overly burdensome.

Dr. Clark suggested that the question of how HIT will support 21st century science is critical to the research infrastructure. Dr. Tang pointed out the issue of workforce training has not received enough

attention. He clarified that by workforce training, he means the training of the individuals who will help all of the physician practices and health care organizations to implement HIT in ways that can be used effectively, in addition to the general training of the professional workforce. Both of those issues have been underplayed but are critical to HIT's effective use.

Dr. Lansky turned the discussion back to the timeline issue, commenting that it would be helpful for the Committee to identify opportunities for early success. He added that if the Committee selects the opportunities appropriately, all of the goals that have been articulated can be achieved, and made visible to the public. Ms. Bechtel agreed, and followed up on Ms. Harrell's earlier comments regarding a ladder/step-by-step approach. Ms. Bechtel indicated that in care coordination for example, this would create a road map that the HIT Standards Committee could consider. It would be an approach for experts to discuss the technical nature of the information and standards in a way that gets at how to make significant progress.

Dr. White Delaney affirmed previous comments made related to the research infrastructure, support, and workforce training. She voiced her support for these areas being included in the meaningful use definition.

Mr. Chapman also voiced support for the ladder/step-by-step approach, given the complexity of the goals facing the Committee. He noted that if there is any marked failure of groups in the past it has been that their recommendations are so comprehensive that they are not implementable. These functional areas could all be explored in depth, but the foundational message is that these have to be implementable in the short term. Mr. White commented on the concepts of workforce training, adoption, and meaningful use. He emphasized that if the workforce is not engaged at an early level, all of the macro-conversations will be almost useless. Unless the workforce is trained properly, and there is an understanding of their role in the bigger picture, these efforts will likely fail from the beginning. Ms. Faulkner warned fellow Committee members of the dangers associated with requiring the software companies to do certain things that they may not be able to do. Particularly in the areas of privacy and security, it must be very crisply and clearly laid out what can be done, what cannot be done, and what is required.

Following a brief break, Dr. Blumenthal turned the conversation to the establishment of working groups. Based on previous discussions, he noted that there are at least three areas in which the Committee wants to carry out intensive work: (1) defining meaningful use, (2) defining or improving certification, and (3) the area of patient-centeredness (e.g., assuring patient access to their health information). Other possibilities include areas such as workforce and infrastructure development. Dr. Blumenthal suggested that the issue of quality falls under the auspices of "meaningful use" because the statute defines quality reporting as an aspect of meaningful use. Similarly, the issue of exchange could fall under meaningful use because the statute requires some level of exchange to define meaningful use.

Ms. McGraw commented that she would be somewhat reluctant to have a workgroup set off to the side to work on privacy and security issues. She indicated that she has no problems with creating a workgroup to dive deeper into some discrete, difficult questions relating to privacy and security. However, since the tone of the earlier discussions were about privacy being foundational to each and every one of the aspects under consideration, she expressed concern that all privacy and security issues will be handed over to the workgroup, and thus the issues could be addressed out of the contexts from which they arise. She noted that one area for focus could be the technical issues related to privacy and security, and whether the HIT field takes full advantage of technologies that have been developed to protect privacy and security in other domains, even within the federal government. Although that would be a fairly minimal charge, Ms. McGraw indicated that it is core to the HIT Policy Committee.

Dr. Tang asked about the possibility of moving privacy under the umbrella of infrastructure. Another Committee member expressed support for this concept, as long as it does not create the idea that the Committee/workgroup is neglecting privacy by not creating a specific workgroup for it. It was noted that although privacy issues have been vetted and addressed in many electronic medical record packages, direct patient access has not. Historically, doctors have analyzed the data and presented it to the patient. Much of the information is sensitive, nuanced, and in some cases can be catastrophic to the patient. It was suggested that there currently is no plan in place for moving forward on how to address suspicious biopsies or disturbing laboratory reports, for example. One Committee member indicated that direct patient access to medical records must be a part of the workgroup focused on privacy in a patient-centric record.

Mr. Probst expressed hope that health information exchange, whether included in the meaningful use discussion or elsewhere, will receive enough attention from the Committee. He commented that health information exchange will be key to a great deal of the meaningful use discussion. Ms. Bechtel asked how time-limited the group dealing with meaningful use will be. She acknowledged having difficulty distinguishing between the goals of a workgroup on meaningful use and some of the larger goals of the HIT Policy Committee. Dr. Blumenthal said that to some degree, this is the Committee's choice. He agreed that meaningful use is a time-limited exercise, but not exclusively time-limited because associated with the requirement of specifying a set of meaningful use criteria for 2011 is the Committee's option to update the criteria.

Ms. Harrell asked whether health information exchange would be addressed within the context of meaningful use or within the context of infrastructure. Dr. Blumenthal explained that there is an aspect to health information exchange that falls under infrastructure because at least $300 million will be spent on it. So, apart from whatever theoretical definitions will be created for it, there is money that must be spent. The question is, for what? That is the infrastructure issue. He added that there also is a meaningful use component tied to health information exchange (i.e., what are the requirements that should be put forth for the meaningful use definition for the exchange, and what do the records have to be able to do to be able to be certified as capable for working exchange?).

Dr. Blumenthal suggested that ONC staff develop a set of guiding principles and circulate them to the Committee members for comments and input. This would then serve as the basis for discussions and decisions that will lead the workgroups. Ultimately, HIT Policy Committee members decided to form the following three workgroups:

- Meaningful Use.
- Certification/Adoption (with the focus being on certification first—this group will also be tasked with infrastructure issues).
- Information Exchange.

## HIT Standards Committee Recommendations

Dr. Blumenthal then proposed that the HIT Policy Committee relay the following to the HIT Standards Committee: (1) that the three workgroups to be formed represent the three primary areas of work; (2) that the statute requires that they focus on meaningful use; and (3) that this group will inform the HIT Standards Committee, as soon as possible, on recommendations concerning meaningful use. The HIT Standards Committee can begin thinking about the process that would be required to get to standards

regarding meaningful use and then wait for a fairly quick set of more defined criteria for meaningful use from the HIT Policy Committee.

## Public Comment

The following was noted during the public comment session:

- Dr. Alan Zuckerman of the American Academy of Pediatrics expressed hope that this Committee will be willing to consider some of the barriers associated with interoperability certification efforts. According to Dr. Zuckerman (who also serves as Co-Chair of the Certification Commission for Health Information Technology's [CCHIT] Interoperability Workgroup), most important will be this Committee's policy affirmation on meaningful use, because many vendors persist in doing things that the customers do not ask for. He also noted that children are vulnerable populations not just in health care, but they are also being left out of HIT in general and in the meaningful use considerations. He suggested that the Committee could select a few targets such as vaccine administration and obesity prevention through checking growth; this is a unique convergence of hospital, ambulatory, public and private sector data for children. His hope is that children will not be neglected in the limited range of targets.

- Mr. Rick Blake, Senior Health Policy Advisor for Rep. Edolphus Towns (D-NY) noted that the House health disparity bill is moving through its paces, and it will have an impact on health disparities for vulnerable, minority populations. He expressed hope that the infrastructure workgroup will be mindful of the fact that this area of data collection could have a positive impact on the reduction of health disparities.

- Another speaker congratulated the group, and reminded them that a lot of the activities that have been moving forward these last several years have been volunteer-driven. As the Committee moves forward with ideas about what the industry and health care community need to do, it should be considered that there are thousands of hours of volunteer work behind these efforts. The speaker noted that meaningful use is the common, binding question of concern among all constituencies. The sooner there can be clarification and education on what meaningful use means, the better.

- Brian Wagner of the e-Health Initiative stressed the importance of work on local levels. His group has been surveying HIT across the country, and the need for human/social capital is important. As these issues move forward on the federal level, it is important to think about promoting that social and human capital and participation so that the projects have as much support at the local level as possible to avoid any sort of catastrophic failure.

- Phil Barr from Thomson-Reuters noted that the certification addresses software and vendors but does not necessarily recognize the complexity of the health system and the issue of whether vendors can and will participate in the exchanges. He commented that certification should be carried out in some way to ensure that vendors are covered for a variety of very specific use cases, and can share information in a minimum data set.

- Mike Dunney (sp?) noted that the bulk of the Committee's discussions focused on the transfer of medical records. When he read through the bill, there was a section that discussed other technologies related to HIT. He expressed interest in whether the Committee will examine other technologies that are more preventive in nature that produce the records being discussed. He also noted that long-term care will be a major issue facing the health care system in the coming years. He noted that there are

technologies that interface with long-term care records only and asked whether these technologies will be considered in the $20 billion initiative. Dr. Blumenthal responded that the law itself does not specify or focus on long-term care. Ms. Daniel commented that there likely is flexibility to take on the issue of long-term care if the Committee and HHS chooses to do so.

## Adjournment

Dr. Blumenthal asked that Committee members inform Ms. Sparrow regarding which workgroup they would like to join. Before adjourning the meeting, he thanked Committee members and others present for their participation and comments.

## Additional Public Comments

In addition to those noted previously, a number of comments were submitted to ONC staff following conclusion of the meeting. These comments are as follows:

- Fred Buhr, President of Metasteward LLC, indicated that "meaningful use" should include patient education/training on how to use HIT. From a patient's point of view, the definition of "meaningful use" should be crisp, clear, and understandable.

- Dr. Zuckerman submitted a letter to ONC staff expanding on the comments he made during the meeting. He noted that the CCHIT has learned many lessons in terms of developing a certification process derived from standards, and that these lessons learned should be shared with the Committee. The Committee can do a great deal to overcome the problems and resistance the CCHIT faced by setting clear "meaningful use" goals for information exchange so that they can get into certification because EHR vendors do not want to implement features that their customers are not asking for and often are unable to use because of lack of interoperability partners and networks. Dr. Zuckerman explained that information exchange must be a routine part of nearly every patient encounter. An important part of this Committee's deliberations on meaningful use should focus on the information required to make meaningful decisions such as carrying out electronic prescribing in the context of patient problems, medications, and allergies, as well as formulary information or regularly checking immunization status of children and adults.

  Dr. Zuckerman also noted that interoperability is a very difficult task to achieve and simplification and clarification of standards and moving resources and privacy protection into networks will help make meaningful EHR certification possible. One of the expectations for certification that he finds among his pediatric colleagues is that one should be able to move a patient record from one certified EHR to another certified EHR so that patients can move to another practice regardless of the EHR used and so that providers will have less fear of choosing the wrong EHR or having their EHR vendor go out of business. If a phased and incremental approach is accepted, this may be possible by 2011. Dr. Zuckerman also expressed hope that the Committee pays due attention to making recommendations on technologies that address the needs of children and other vulnerable populations. Children are a vulnerable population not just in their health risks but in terms of being left out of HIT because they cannot speak for themselves.

- Ilyse Schuman, Managing Director of the Medical Imaging and Technology Alliance (MITA), submitted a letter on behalf of the organization express its views for incorporation into the public record, to describe MITA's capabilities in standards development, and to offer its assistance and

expertise on the issues vital to the successful achievement of the Nationwide Health Information Network (NHIN). She noted that MITA is the collective voice of medical imaging manufacturers, innovators and product developers. It represents companies whose sales comprise more than 95 percent of the global market for medical imaging technology and has developed standards for many areas including diagnostic ultrasound, nuclear medicine imaging, magnetic resonance imaging, x-ray imaging and radiation therapy. Based on its knowledge and experience, MITA is able to provide recommendations and advice on these and other areas that are central to the development of the NHIN. She noted that improved access to imaging through the NHIN can reduce errors and delays in care, and has the potential to decrease the number of unnecessary duplicate examination, and thus reduce cost and patient exposure to radiation.